MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

11200

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN National
LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN National
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Leo (Last) Aldridge

4. DATE OF DEATH: (Month) Dec (Day) 28 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: - - 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroader

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Aldridge

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Joseph Aldridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Heart failure — 1 week

450.0 97

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 10 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Adolph Wolferman M.D. ADDRESS Frostburg DATE SIGNED 12-29-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF Dec 30, 1949 — NAME OF CEMETERY OR CREMATORY Allegany Cemetery — LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 12-29-49 — REGISTRAR'S SIGNATURE Jeannette M Boal

24. FUNERAL DIRECTOR M. Eichhorn — ADDRESS Lonaconing, Md.

RECEIVED
JAN 4 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

11301

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) route40 Neare Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highway near All Ghan Country Club, Baltimore Pike

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 614 Troy St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| James | W. | Alkire | Dec | 6 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | June 4-1903 | 46 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supply man | B&O.R.Ry | Mt. Savage Md | U.S.A. |

13. FATHER'S NAME: Ray T. Alkire
14. MOTHER'S MAIDEN NAME: Minnie Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-12-5690
17. INFORMANT: Wife) Virgie Twigg Alkire

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Intrathoracic hemorrhage due to rupture of | at once |
| 812.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 170c | (b) heart & lungs from fractured ribs left side | |
| | (c) of chest. Hit by an automobile. | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway
(CITY OR TOWN) East of Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 6/49 - about A m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Walking on highway Hit by an automobile.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | Cumberland Md. | Dec.6-1949 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec.8,1949 | Mt. Zion | Near Short Gap, W. Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 8, 1949 | Wirta R. Frantz M.D. | Charles L. George | Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 13 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11302

# CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
LENGTH OF STAY (in this place) 56 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Foundry Row

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) Foundry Row

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Thresa (Last) Baker
4. DATE OF DEATH (Month) 12 (Day) 16 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 6-22-1880
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bean's Cove, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Riley Bridges
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mrs James E. Baker Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Nephritis | 5 years |
| Antecedent cause(s) | (b) Vascular Hypertension | Several years |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Gangrene of both legs | 2 weeks |

447
131a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1945, to Dec-15, 1949, that I last saw the deceased alive on Dec-15, 1949, and that death occurred at 4:00 P m., from the causes and on the date stated above.

SIGNATURE William E. Moseley (Degree or title) ADDRESS Mt Savage, Md. DATE SIGNED 12-19-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 12-20-49
NAME OF CEMETERY OR CREMATORY Methodist Cem.
LOCATION (City, town, or county) Mt. Savage, (State) Md.

DATE REC'D BY LOCAL REG. 12-19-49
REGISTRAR'S SIGNATURE Vernesa McDermott
24. FUNERAL DIRECTOR Jacob Hafer, ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 27 1949
BUREAU U. S.

Within corporate limits

DR. W. F. WMS. 65

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

11303

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 1 DAY; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: PENN.; COUNTY: SOMERSET; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SOMERSET, Rural; STREET ADDRESS (If rural, give location): RT # 2

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) A. (Last) BAUGHMAN

4. DATE OF DEATH: (Month) DEC. (Day) 30 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 16 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY BAUGHMAN

14. MOTHER'S MAIDEN NAME: MARY MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mary E. Baughman, RD#2 Somerset, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardial Degeneration ?

4222 Antecedent cause(s)

933 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-29, 1949, to 12-30, 1949, that I last saw the deceased alive on 12-29, 1949, and that death occurred at 7:00 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. F. Williams ADDRESS Cumberland DATE SIGNED 12-30-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan 2, 1950 NAME OF CEMETERY OR CREMATORY Weller Cemetery LOCATION (City, town, or county) (State) Somerset Co., Penna.

DATE REC'D BY LOCAL REG. Dec. 30, 1949 REGISTRAR'S SIGNATURE Wirter K. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland, Md.

RECEIVED
JAN 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

11304

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) near Cumberland
LENGTH OF STAY (in this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.2 Murley Branch Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) near Cumberland
STREET ADDRESS (If rural give location) R.F.D.2 Murley Branch Road.

3. NAME OF DECEASED (Type or Print) (First) Daniel (Middle) (Last) Bender
4. DATE OF DEATH (Month) Dec. (Day) 14 (Year) 1949
5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH April-10-1876
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Rural near Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Augustus Bender
14. MOTHER'S MAIDEN NAME Elizabeth Peters ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT Weldon D.Bender (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| 94a | (c) Arteriosclerosis & hypertention | ? |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Dec 14-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec 16, 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland, (State) Md
DATE REC'D BY LOCAL REG. Dec 16. 1949
REGISTRAR'S SIGNATURE Nina L. Bender
24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
DEC 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

11305

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 12 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.Va — COUNTY: Pendleton
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cherry Grove
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Lizzettie (Middle) (Last) Bennett

4. DATE OF DEATH: (Month) Dec. (Day) 9 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept.1-1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cherry Grove W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Saul Mick

14. MOTHER'S MAIDEN NAME: Catherine Lambert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Olen Bennett (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 2nd.&3rd. burns of body & face — 12 hrs.

9160

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

181

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.): house
302 Independence St. Cumberland Allegany Md.
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec.9/49 A. 9.20 m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Clothes caught fire from a small gas stove in kitchen.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. Dec.10-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 12/11/49 — NAME OF CEMETERY OR CREMATORY: Cherry Grove — LOCATION (City, town, or county): Cherry Grove — (State): W.Va

DATE REC'D BY LOCAL REG.: Dec. 11, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: William H. Light — ADDRESS: Cumberland Md

VS. A15A

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11306

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 18 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 309 Holland Street

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| Micheal | Oscar | Blake | Dec. 29, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 7/26/1876 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer Dept | Celanese Corp. | Eckhart, Maryland | USA |

13. FATHER'S NAME: Phillip Blake

14. MOTHER'S MAIDEN NAME: Margaret Bean

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | 217 10 4405 | Katherine Blake Cumberland, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Broncho pneumonia | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Silicosis | 20 years |
| | (c) | |

523.0 107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Nov 1, 1949, to Dec. 23, 1949, that I last saw the deceased alive on Dec 29, 1949, and that death occurred at 10:00 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. G. Bellis, M. D. ADDRESS 62 Greene St. Cumberland Md DATE SIGNED 12/30/49

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/1949 | St. Michaels Cemetery | Frostburg, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Dec 30, 1949 | Minter L. Clark, MD | William H. Kight, Cumberland, Md. |

RECEIVED
JAN 4 1950
BUREAU V. S.

Outside of City limits

11307

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural North Branch Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.#4 Box208

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) North Branch Cumberland
STREET ADDRESS (If rural give location): R.F.D.#4 Box 208

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Nora | May | Bloss | Dec. | 2 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | May 30-1899 | 50 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | --- | Mexico Farms, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank C. Baldwin | Sally Long |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uoknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | none | Frank Bloss |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage (apoplexy) | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| 331 530 | (c) Hypertention | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H. V. Deming M.D. | Cumberland Md. | Dec.2-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5 49 | Davis Memorial and Rural | Cumberland Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 5, 1949 | Walter K. Frantz, M.D. | Louis Stimpson | " |

VS. A15A

RECEIVED
DEC 13 1949
BUREAU V. S.

Within corporate limits

11308

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 612 Sylvan Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 612 Sylvan Ave.

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Lora (Last) Bockhouse
4. DATE OF DEATH (Month) Dec. (Day) 9 (Year) 1949
5. SEX female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH March31-1876
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sommerset Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Christopher Leydig
14. MOTHER'S MAIDEN NAME Louise Bower
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT John Bockhouse (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic myocarditis | 6 years |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerosis | ? |
| | (c) Hypertention | ? |

443
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Dec.10-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial. DATE THEREOF 12/12/49 NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Dec. 11, 1949 REGISTRAR'S SIGNATURE Winter R. Wantz, M.D.
24. FUNERAL DIRECTOR Harvey H. Leigler ADDRESS Hyndman Pa

Zinglor

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 22 1949
BUREAU V. S.

Hodges

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11309

# CERTIFICATE OF DEATH

Reg. Dist. No. 1

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Twigglown
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.D.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Twigglown
STREET ADDRESS (If rural, give location): R.D.

**3. NAME OF DECEASED** (Type or Print): (First) Harriet (Middle) Elizabeth (Last) Bottenfield

**4. DATE OF DEATH**: (Month) Dec (Day) 5 (Year) 1949

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): married

**8. DATE OF BIRTH**: Feb 29 1880

**9. AGE last birthday**: 69 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: Henry North

**14. MOTHER'S MAIDEN NAME**: Elizabeth Athey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: Palmer Bottenfield R.D. Cumb. Md

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Hemmorrhage | 2 hours |
| Antecedent cause(s) | (b) Arteriosclerosis | ? |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

331

83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify):

**PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.:

**INJURY OCCURRED** While at Work ☐ Not While At work ☐

**HOW DID INJURY OCCUR?**:

**22.** I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on Dec 5, 1949, and that death occurred at ?.m., from the causes and on the date stated above.

SIGNATURE: W. Royce Hodges (Degree or title) — ADDRESS: Cumberland, Md. — DATE SIGNED: 12/7/49

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Dec 8, 1949 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Dec. 8, 1949 — REGISTRAR'S SIGNATURE: Mrs. Sue C. Gindrow

**24. FUNERAL DIRECTOR** — ADDRESS: John J. Hofer Cumberland Md.

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DEC 14 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11310

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 424 Balto. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 424 Balto. Ave.

3. NAME OF DECEASED (Type or Print): (First) Wimmer (Middle) (Last) Bowman

4. DATE OF DEATH: (Month) Dec (Day) 26 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Apr 13, 1882

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Oldtown Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George A. Bowman

14. MOTHER'S MAIDEN NAME: Elmira Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs Wimmer Bowman, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Renal failure — Interval Between Onset and Death: 3 months

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

420.0 (b) Hypertensive Vascular Disease and Chronic nephritis — ?

131a (c) Generalized arteriosclerotic Vascular Disease — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Dec. 49, 19..., to 26 Dec. 49, 19..., that I last saw the deceased alive on 24 Dec. 49, 19..., and that death occurred at 5:30A m., from the causes and on the date stated above.

SIGNATURE: W. A. Van Ormer (Degree or title) ADDRESS: Cumberland Md DATE SIGNED: 27 Dec. 49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Dec 29, 1949 NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery LOCATION (City, town or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Dec. 27, 1949 REGISTRAR'S SIGNATURE: Wintek K. Hantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland Md

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JAN 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11311

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; MARYLAND LENGTH OF STAY (In this place): 44 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 159 N. Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) G. (Last) Canan

4. DATE OF DEATH: (Month) Dec. (Day) 13 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 29-1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper in Cafeteria

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Grant Co. W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Canan

14. MOTHER'S MAIDEN NAME: Katherine Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 233-09-0029

17. INFORMANT: Mrs. Edwin Canan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 **Immediate cause** (a) Pulmonary embolism due to contusions — Interval between onset and death: 44 days

170 C **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hit by automobile.

(c) also had a fracture of right malar bone.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.): street (CITY OR TOWN): Cor. George & Baltimore Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 29/49 6.30 P. m. INJURY OCCURRED While at work ☐ Not while at work ☒ HOW DID INJURY OCCUR? Walking across St. hit by an auto.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H.V. Deming M.D. Cumberland Md. — DATE SIGNED: Dec. 13-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 12/16/1949 | NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 16, 1949 | REGISTRAR'S SIGNATURE: Hunter R. Dantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: William H. Kight Cumberland, Md.

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DEC 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11312

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | STREET ADDRESS (If rural, give location) 449 Columbia St. |

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Vincent | | Carpenti | | 12 | 18 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | W | 9-16-77 | 72 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Prop. City Cafe | | Fana Andriano, Italy | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Peter Carrenti | Clementina De Marco |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| NO | None | Rita Spaulding (daughter) |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Uremic Poisoning | 2 yrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive cardiovascular renal disease | 3 yrs |
| | (c) | |

442
131a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Nov. 10, 1949, to Dec 18, 1949, that I last saw the deceased alive on Dec. 17, 1949, and that death occurred at 5:50 P.M. from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones M.D. | | 110 S. Centre St. | Dec. 19, 1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | St. Patrick's Cem | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 20 1949 | Hunter R. Trantz M.D. | James F. Scarpelli | Cumberland, Md. |

VS. 715

RECEIVED
DEC 28 1949
BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A14

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11313

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 18 mos. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital | STREET ADDRESS (If rural, give location) 276 E. Main St. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) SALLY | (Middle) JO | (Last) CLOSE | 4. DATE OF DEATH | (Month) Dec. (Day) 19, (Year) 1949 |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single | 8. DATE OF BIRTH 12-1-1947 | 9. AGE last birthday 2 yrs. | If under 1 year Months. Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. none | 17. INFORMANT AND ADDRESS Miss Marian Close, Washington, D. C. | | | |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Dehydration | 6 hours |
| Antecedent cause(s) 472.1 | (b) Acute Gastritis | 48 hrs |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 115C | (c) Acute Pharyngitis | 48 hrs |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) no | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 12/17, 1949, to 12/19, 1949, that I last saw the deceased alive on 12/19, 1949, and that death occurred at 3 50 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Hilda Jane Walters | M.D. | Frostburg Md | 12/20/49. |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 12-22-49 | NAME OF CEMETERY OR CREMATORY Eckhart Cemetery | LOCATION (City, town, or county) (State) Eckhart, Md. |
| DATE REC'D BY LOCAL REG. 12.22.49 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe | 24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. | ADDRESS |

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DEC 29 1949
BUREAU V. S.

Dr. Alise

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11314

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 519 Henderson Ave. | STREET ADDRESS (If rural, give location) 519 Henderson Ave. |

3. NAME OF DECEASED (Type or Print) (First) Alice (Middle) Agnes (Last) Cole

4. DATE OF DEATH (Month) Dec. (Day) 18, (Year) 1949

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months. | Days | If under 24 hrs. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | June 28, 1874 | 75 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Berryville, Va. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John A. McCormick | Susan Athey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| No | | None | Gilbert Cole Cumberland, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Failure | 12 hrs |
| Antecedent cause(s) | (b) Arterio Sclerosis | Undetermined |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Aug., 1948, to 12/17, 1949, that I last saw the deceased alive on 12/17/, 1949, and that death occurred at 11:20 P.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS 404 Decatur St. Cumberland DATE SIGNED 12/20/49

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | HillCrest Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec 21, 1949 | Winter R Trantz, M.D. | Charles L. George | Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 28 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11315

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 461 Central Ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): William M. Connell
4. DATE OF DEATH (Month) (Day) (Year): 12 - 19 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: May 30 1880
9. AGE last birthday: 69 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Desk Sergeant Retired
10b. KIND OF BUSINESS OR INDUSTRY: Police Dept
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Connell
14. MOTHER'S MAIDEN NAME: Mary Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: William M. Connell, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause | (a) | Auricular Fibrillation | 2 mo |
| 450.0 Antecedent cause(s) | (b) | Chronic nephritis | 1 yr. |
| 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | Generalize arteriosclerosis | 1 yr. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-27, 1949, to 12-9-, 1949, that I last saw the deceased alive on 12-9, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE: C. C. Zimmerman (Degree or title)
ADDRESS: Cumberland Md
DATE SIGNED: 12-10-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Dec. 12 '49
NAME OF CEMETERY OR CREMATORY: St Patricks Cem
LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: Dec. 11, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D
24. FUNERAL DIRECTOR: Louis Stein Inc.
ADDRESS:

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DEC 22 1949
BUREAU V. S.

11316

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing — LENGTH OF STAY (in this place) 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jackson Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Jackson Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Catherine (Last) Custer
4. DATE OF DEATH: (Month) Dec (Day) 1 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widdowed
8. DATE OF BIRTH: Nov 14, 1872
9. AGE last birthday: 77 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clark
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Custer

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Myocardial insufficiency | 1 day |
| 422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 63b | (b) Chronic Myocarditis | 1 yr |
| | (c) Toxic Adenoma | 1 yr. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/1, 1949, to 12/1, 1949, that I last saw the deceased alive on 12/1, 1949, and that death occurred at 5:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Thomas Reeves M.D. Westernport, Md 12/3/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Dec 4, 1949
NAME OF CEMETERY OR CREMATORY: Laural Hill Cemetery
LOCATION (City, town, or county) (State): Moscow, Md

DATE REC'D BY LOCAL REG. 12/5/49
REGISTRAR'S SIGNATURE: Jeanette McFoal
24. FUNERAL DIRECTOR: M. Eichhorn
ADDRESS: Lonaconing, Md.

VS. A15

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11317

2411 N. Charles Street, Baltimore

1454

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.-A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 64 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 619 Lynn Street

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 619 Lynn Street

**3. NAME OF DECEASED** (Type or Print): (First) Bessie (Middle) Lee (Last) Darkey

**4. DATE OF DEATH**: (Month) Dec (Day) 8 (Year) 1949

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH**: Oct 2 1885

**9. AGE last birthday**: 64 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House

**10b. KIND OF BUSINESS OR INDUSTRY**: House Wife

**11. BIRTHPLACE** (State or foreign country): Cumberland, Maryland

**12. CITIZEN OF WHAT COUNTRY?**: US

**13. FATHER'S NAME**: Charles J. Cox

**14. MOTHER'S MAIDEN NAME**: Claribel Coffey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: Wm A. Darkey, 619 Lynn St, Cumberland, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset and Death: 6 mos

170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
50 (b) Carcinoma of Breast — 4 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from Jan, 1945 to Dec 8, 1949, that I last saw the deceased alive on Dec. 6, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE: W. W. Eleason — (Degree or title) M.D. — ADDRESS: 126 Union St. — DATE SIGNED: Cumberland Md.

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Dec. 11, 1949 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 9, 1949 — REGISTRAR'S SIGNATURE: Walter R. Krantz, M.D. — **24. FUNERAL DIRECTOR** — ADDRESS: William H. Kight, Cumberland, Md.

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DEC 13 1949
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Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

11318

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 30 yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 508 Baltimore Ave | STREET ADDRESS (If rural, give location): 508 Baltimore Ave. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Anne | M. | Davis | Dec | 19 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | Widowed | June 21 1867 | 82 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own home | Frostburg Md | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Phillip Oss | Mary Houser |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Harry Davis 26 Marion St Cumb |

### 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Apoplexia | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) coronary occlusion | 2 weeks |
| | (c) | |

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan, 1946, to Dec 19, 1949 that I last saw the deceased alive on Dec 18, 1949 and that death occurred at .....m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Elizabeth Bruns M.D | | 55 Greene St. | 12/20 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Dec 21, 1949 | Greenmount Cemetery | Cumberland | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec 21, 1949 | Hunter R Trantz, MD | John J. Hafer | Cumberland Md |

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DEC 28 1949
BUREAU V. S.

Dr. McLane

11319

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Frostburg
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) FLORENCE (Middle) (Last) DAVIS

4. DATE OF DEATH: (Month) Dec. (Day) 7, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-12-1873

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Buckalew

14. MOTHER'S MAIDEN NAME: Martha Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: John Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetes — Interval between onset and death: Several years

260 Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arterio Sclerosis Post Hemiplegia Syndrome — 2 yrs

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1945, to Dec. 7, 1949, that I last saw the deceased alive on Nov. 15, 1949, and that death occurred at 4:45 P.m., from the causes and on the date stated above.

SIGNATURE: W. McLane M.D. (Degree or title) — ADDRESS: Frostburg Md. — DATE SIGNED: 12-7-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 12-9-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 12-9-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15

RECEIVED
DEC 15 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

11320

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 410 Springdale St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 410 Springdale St.

3. NAME OF DECEASED (Type or Print): (First) Harriet (Middle) Crabtree (Last) Davis

4. DATE OF DEATH: (Month) Dec. (Day) 6 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: March 4-1862

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mt. Savage Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Logsdon

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Emma Myers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (e) Bronchopneumonia — 1 week

491

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

107

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Dec. 6-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Dec 9, 1949
NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Dec. 9, 1949
REGISTRAR'S SIGNATURE: Walter K. Hartz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer Cumberland, Md.

RECEIVED
DEC 13 1949
BUREAU V. S.

11321

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Little Orleans
LENGTH OF STAY (In this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Little Orleans
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Robert Lee Davis

4. DATE OF DEATH (Month) (Day) (Year) Dec. 13 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced

8. DATE OF BIRTH Unknown

9. AGE last birthday About 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Unknown Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Charles Ayers, Wiley Ford, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic myocarditis | about 12 |
| 422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) also had Bronchial asthma | years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V. Deming (Degree or title) ADDRESS Cumberland Md. DATE SIGNED Dec.13-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Dec 17,1949

NAME OF CEMETERY OR CREMATORY Methodist Cemetery

LOCATION (City, town, or county) (State) Little Orleans, Md

DATE REC'D BY LOCAL REG. Dec. 17, 1949

REGISTRAR'S SIGNATURE Winter R. Trantz M.D. Mrs. Sue Grissom

24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 27 1949
BUREAU U. S.

DR. DYER

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11322

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 18 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 22 POTOMAC STREET

**3. NAME OF DECEASED** (Type or Print): (First) WALLACE (Middle) (Last) DAVIS

**4. DATE OF DEATH**: (Month) DEC. (Day) 7 (Year) 1949

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED.** (Specify): WIDOWED

**8. DATE OF BIRTH**: JUNE 18/1891

**9. AGE** Last birthday: 58 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): NONE

**10b. KIND OF BUSINESS OR INDUSTRY**: Retired Coal Miner

**11. BIRTHPLACE** (State or foreign country): WEST VIRGINIA

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: THOMAS A. DAVIS

**14. MOTHER'S MAIDEN NAME**: ELIZABETH BRAY

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If year, give war or dates of service)

**16. SOCIAL SECURITY NO.**: 216-01-4833

**17. INFORMANT AND ADDRESS**: MEMORIAL HOSPITAL

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Immediate cause** (a): Cardiac decompensation

420.1 94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Coronary occlusion

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from Nov., 1948, to Dec. 7, 1949, that I last saw the deceased alive on Dec. 7, 1949, and that death occurred at 9:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Hunter A. Dyer, M.D. — ADDRESS: 247 Va. Ave — DATE SIGNED: 12-8-49

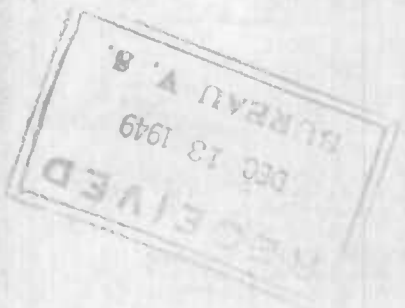
**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial | DATE: Dec 10 1949 | NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemetery | LOCATION (City, town, or county) (State): Elk Garden, W. Va.

DATE REC'D BY LOCAL REG.: Dec. 9, 1949 | REGISTRAR'S SIGNATURE: Winter L. Hantz, M.D.

**24. FUNERAL DIRECTOR** | ADDRESS: O. F. Sharpless, Blaine, W. Va.

VS-A15

Telephone 1454



Within corporate limits

Evidence for change of age shownon;

FILM No. G 1 24 FEB 6 1950

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11323

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Cumberland~~ McCoole |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | STREET ADDRESS (If rural, give location) 24 Queen St., McCoole, Md. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Charles | (Middle) E. | (Last) Duckworth | 4. DATE OF DEATH | (Month) 12 (Day) 21 (Year) 1949 |
| 5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W | 8. DATE OF BIRTH Dec. 14, 1883 | 9. AGE last birthday 66 ~~76~~ yrs. | If under 1 year Months / Days; If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serv. Sta. Attendant | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Fort Ashby, W. Va. | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Thomas Duckworth | | | 14. MOTHER'S MAIDEN NAME ~~Caroline~~ Baker | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT AND ADDRESS Brooke Duckworth - son | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostatic Bronchopneumonia — 1 wk

Antecedent cause(s)

491

107

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Sept. 15, 1949, to Dec. 21, 1949, that I last saw the deceased alive on Dec. 20, 1949, and that death occurred at 2:28 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M.D. | 110 S. Centre St. | Dec. 21, 1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 23, 1949 | Queen's Point Cem. | Keyser, West Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 21, 1949 | Winter R. Frantz, M.D. | J. H. Markwood Sons, | Keyser West Virginia |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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4

RECEIVED
DEC 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11324

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 114 Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 114 Centre St.

3. NAME OF DECEASED (Type or Print): (First) EDWIN (Middle) (Last) ELIAS

4. DATE OF DEATH: (Month) Dec. (Day) 15, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 6-14-1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Insurance ag't.

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Elias

14. MOTHER'S MAIDEN NAME: Margaret Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Edwin Elias, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 1 day

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteria Sclerosis. Hypertension — Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 18, 1947, to Dec 15, 1949, that I last saw the deceased alive on Dec 13, 1949, and that death occurred at 1:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W M^c Lane M D — ADDRESS: Frostburg Md — DATE SIGNED: 12-16-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 12-17-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 12-17-49 — REGISTRAR'S SIGNATURE: Mrs. Hailey N. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

Dr Hodges

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11325

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oldtown
STREET ADDRESS (If rural, give location): R F D I

3. NAME OF DECEASED (Type or Print) (First) Lavinia (Middle) (Last) Flake

4. DATE OF DEATH (Month) Dec (Day) 19 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 20, 1876
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm Browning
14. MOTHER'S MAIDEN NAME: Julia Imes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Curtis Middleton R.F.D.1 - Oldtown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemaplegia left — 1 week

334 Antecedent cause(s) Cerebral Arteriosclerosis

83d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 13, 1949, to Dec 19, 1949, that I last saw the deceased alive on Dec 19, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: W. Royce Hodges (Degree or title) — ADDRESS: Cumberland, Md. — DATE SIGNED: 12/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Dec 21, 1949 — NAME OF CEMETERY OR CREMATORY: Pleasant Grove Meth. Cem. — LOCATION (City, town, or county): Near Cumberland (State): Md

DATE REC'D BY LOCAL REG.: Dec 21 1949 — REGISTRAR'S SIGNATURE: Hunter R Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hafer - Cumberland Md. — ADDRESS:

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DEC 28 1949
BUREAU V. S.

Within corporate limits

11326

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 504 South Fourth Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
STREET ADDRESS (If rural, give location): 504 South Fourth Street

3. NAME OF DECEASED (Type or Print): (First) Laura Elva (Middle) (Last) Fleegle

4. DATE OF DEATH: (Month) 12 (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 8/2/1874

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Shatzer

14. MOTHER'S MAIDEN NAME: Dorkas Stallings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Pearl Cochran

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 8 wks |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) General Arteriosclerosis | 1 yrs |
| 260 61 | (c) Diabetes | 10 yrs |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐:
HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Feb, 1947, to Dec. 22, 1949, that I last saw the deceased alive on Dec. 20, 1949, and that death occurred at 1.30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Dec. 23, 1949

23. BURIAL, CREMATION REMOVAL, (Specify): Burial — DATE THEREOF: 12/24/49 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Dec. 23, 1949 — REGISTRAR'S SIGNATURE: Winter R. Mentz, M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Pa.

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DEC 28 1949
BUREAU V. S.

DR.W.F.WMS.

11327

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, — LENGTH OF STAY (in this place) 3 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
STREET ADDRESS (If rural, give location) 867 GEPHART DRIVE

3. NAME OF DECEASED (Type or Print): (First) ELUE (Middle) O. (Last) FRITCH

4. DATE OF DEATH: (Month) DECEMBER (Day) 16, (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 6/13/1883

9. AGE last birthday: 66 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): KELLY SPRINGFIELD TIRE CO.

10b. KIND OF BUSINESS OR INDUSTRY: Tire Engineer

11. BIRTHPLACE (State or foreign country): OHIO, Stark, Co.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Fritch

14. MOTHER'S MAIDEN NAME: MARY MOTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Dissecting Aneurysm — 4 hrs

450.0

Antecedent cause(s)

96

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — L.D.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-16-, 1949, to 12-16-, 1949, that I last saw the deceased alive on 12-16-, 1949, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

SIGNATURE: Wm. F. Williams (Degree or title) — ADDRESS: Cumberland — DATE SIGNED: 12-17-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Dec. 20 1949 — NAME OF CEMETERY OR CREMATORY: Glendale Cem. — LOCATION (City, town, or county): Akron, Ohio (State)

DATE REC'D BY LOCAL REG.: Dec. 17, 1949 — REGISTRAR'S SIGNATURE: Hunter D. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. Georg — ADDRESS: Cumb. Md.

RECEIVED
DEC 22 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

11328

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Park Avenue

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Peter (Pietro) Gaudio

4. DATE OF DEATH (Month) (Day) (Year) 12 / 27th 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH June 29, 1900

9. AGE last birthday 49 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Calvinist Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Gaudio

14. MOTHER'S MAIDEN NAME Marietta Sicoli

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) World War I (If year, give war or dates of service) Italy

16. SOCIAL SECURITY NO. 214-01-0331

17. INFORMANT AND ADDRESS Anthony Gaudio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: General months

181 Antecedent cause(s)

52b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Bladder — General months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ? ?

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Bladder

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 16, 1949, to Dec 27, 1949, that I last saw the deceased alive on Dec 16, 1949, and that death occurred at 8 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W O McLane MD Frostburg Md 12-28-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 12/30/49
NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 12-30-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer
ADDRESS Frostburg, Md.

RECEIVED
JAN 4 1950
BUREAU V. S.

11329

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Barton, Maryland
LENGTH OF STAY (in this place) 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Moscow

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural – Barton, Md.
STREET ADDRESS (If rural, give location) Moscow

3. NAME OF DECEASED (Type or Print) (First) Esther (Middle) Cornelious (Last) George

4. DATE OF DEATH (Month) December (Day) 2 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 1-1878
9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Portage, Penna.
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME John Francis Crum
14. MOTHER'S MAIDEN NAME Sophia Rebecca Emeigh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Mrs. Lawrence George

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage | 3 days |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerosis | 10 yrs. |
| | (c) | |

331
830

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1948, to Dec., 1949, that I last saw the deceased alive on Nov. 30, 1949, and that death occurred at 1 50 p.m., from the causes and on the date stated above.

SIGNATURE T. E. Berry M. D. (Degree or title) ADDRESS Piedmont W. Va DATE SIGNED 12/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 12-5-1949
NAME OF CEMETERY OR CREMATORY Mt Hope Cem.
LOCATION (City, town, or county) Portage, Pa. N.D. (State)

DATE REC'D BY LOCAL REG. 12/2/49
REGISTRAR'S SIGNATURE Jannette M Tool
24. FUNERAL DIRECTOR J. L. Carn ADDRESS Claysburg, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11330

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole rural — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole rural |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1 mile east of McCoole | STREET ADDRESS (If rural, give location): 1 mile east of McCoole |

| | | | | |
|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Harold | (Middle) Douglas | (Last) Gordon | 4. DATE OF DEATH (Month) December (Day) 22 (Year) 1949 |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Oct 1, 1949 | 9. AGE last birthday: yrs. — If under 1 year: Months 2, Days — If under 24 hrs.: Hours, Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10b. KIND OF BUSINESS OR INDUSTRY: - - - | 11. BIRTHPLACE (State or foreign country): McCoole, Maryland | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: Harvey L. Gordon | | 14. MOTHER'S MAIDEN NAME: Marion Norris | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service): - - - | 16. SOCIAL SECURITY No.: - - - - - | 17. INFORMANT AND ADDRESS: Harvey L. Gordon | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Broncho-pneumonia — 1 day

491 Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Dec 21, 1949, to Dec 22, 1949, that I last saw the deceased alive on 12/21, 1949, and that death occurred at 800 A m., from the causes and on the date stated above.

SIGNATURE: Thomas Reeves, M.D. (Degree or title) ADDRESS: Westernport, Md DATE SIGNED: 12/23/49

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Dec 24, 1949 | NAME OF CEMETERY OR CREMATORY: Biertown Cemetery | LOCATION (City, town, or county) (State): Rawlings, Maryland |
| DATE REC'D BY LOCAL REG.: Dec 24/49 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: E. S. Boal, Westernport, Maryland | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 30 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11331

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 wk.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Md.
STREET ADDRESS (If rural, give location) Bedford Road Rt 3.

3. NAME OF DECEASED (Type or Print) (First) Daniel (Middle) (Last) Gusis
4. DATE OF DEATH (Month) (Day) (Year) December 26 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Child
8. DATE OF BIRTH June 7, 1949
9. AGE last birthday ~~6~~ yrs. If under 1 year Months 6 Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Newport R.I.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Edward Bernard Gusis
14. MOTHER'S MAIDEN NAME Margaret E. Twigg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Daniel Gusis, Cumberland Rt 3.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) bronchiolitis, bronchopneumonia 6 days

774 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ~~sim~~ paranasal sinusitis

107 (c) was premature baby

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 2, 1949, to Dec. 26, 1949, that I last saw the deceased alive on Dec. 25, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Elizabeth Brings (Degree or title) ADDRESS 55 Greene St. DATE SIGNED 12/26/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec 28, 1949
NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.
DATE REC'D BY LOCAL REG. Dec. 27, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M C I

VS. A15

RECEIVED
JAN 4 1950
BUREAU V. S.

DR. W. F. WILLIAMS

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

11332

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: WEST VIRGINIA — COUNTY: HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ROMNEY
STREET ADDRESS (If rural, give location): ✓

**3. NAME OF DECEASED (Type or Print)**: (First) GLORIA (Middle) (Last) HANNAS

**4. DATE OF DEATH**: (Month) DEC. (Day) 17, (Year) 1949

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)**: SINGLE

**8. DATE OF BIRTH**: DEC. 1, 1935

**9. AGE last birthday**: 14 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**: STUDENT

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE (State or foreign country)**: WEST VIRGINIA

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: EUGENE HANNAS

**14. MOTHER'S MAIDEN NAME**: CLARA ORNDORFF

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: No — (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: MEMORIAL HOSPITAL - CUMBERLAND, MD.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause, (a) Diabetes Mellitus — Interval Between Onset and Death: ?

Antecedent cause(s)

260 61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**:

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from 12-16-, 1949, to 12-17-, 1949, that I last saw the deceased alive on 12-17-, 1949, and that death occurred at 2:45 m., from the causes and on the date stated above.

SIGNATURE: Wm. F. Williams (Degree or title) — ADDRESS: Cumberland — DATE SIGNED: 12/17/49

**23. BURIAL, CREMATION REMOVAL (Specify)**: Burial — DATE: 19 Dec 49 — NAME OF CEMETERY OR CREMATORY: Indian Mound — LOCATION (City, town, or county) (State): Romney W. Va.

DATE REC'D BY LOCAL REG.: Dec. 19 1949 — REGISTRAR'S SIGNATURE: Hunter R. Trout, M.D.

**24. FUNERAL DIRECTOR**: H. C. Ruckman — ADDRESS: Romney. W. Va.

RECEIVED
DEC 28 1949
BUREAU V. S.

MD
Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

11333

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Corriganville
LENGTH OF STAY (in this place): at once
HOSPITAL OR INSTITUTION OR STREET ADDRESS: B&O.R.Ry.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa.; COUNTY: Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mann's Choice (rural)
STREET ADDRESS (If rural give location): R.F.D.1

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Glen | William | Holler | Dec. | 18 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | July 9-1927 | 22 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Spinner | Celanese Corp. | New Buena Vista, Pa. or Mann's Choice Rd. Pa. | U.S.A. |

13. FATHER'S NAME: Oscar Holler
14. MOTHER'S MAIDEN NAME: Blanche Hillegass

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | 209-20-2493 | Undertaker |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Intracranial hemorrhage due to a badly | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) crushed skull | |
| | (c) | |

810.5
1700

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | B&O.R.Ry. | near Corrigansville | Allegany | Md. |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| Dec. 18/49 12.55 A. m. | | Passenger train. Auto stalled on tracks, hit by a |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | | Cumberland Md. | Dec.18-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | 12-21-49 | Schellsburg Cemetery | Schellsburg | Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 19 1949 | Hunter R Frantz, M.D. | Mickle Funeral Home | Schellsburg Pa. |

VS. A15A

RECEIVED
DEC 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11334

# CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. M5

1. PLACE OF DEATH: COUNTY Allegany, Mt. Savage MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage, Md.; LENGTH OF STAY (in this place) life; HOSPITAL OR INSTITUTION OR STREET ADDRESS New Row, Mt. Savage, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage, Md.; STREET ADDRESS (If rural, give location) New Row, Mt. Savage, Md.

3. NAME OF DECEASED (Type or Print): (First) Nannie (Middle) E. (Last) Holsinger

4. DATE OF DEATH: (Month) Dec. (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 19, 1870

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Myers

14. MOTHER'S MAIDEN NAME: Nancy Harden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Lillian Plaskett- daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the liver — Interval between onset and death: 6 months

156.1 Antecedent cause(s)

46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic heart disease

(c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/7/49, 19....., to 12/18/49, 19....., that I last saw the deceased alive on 12/18/49, 19....., and that death occurred at 12:40 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James P. Hallman M.D. 300 Decatur Street Cumberland, Md. 12/19/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 12-21-49 — NAME OF CEMETERY OR CREMATORY: Methodist Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: 12-20-49 — REGISTRAR'S SIGNATURE: Vernon McDermott

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
DEC 27 1949
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

11335

# MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 409 Walnut St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Holtschneider

4. DATE OF DEATH: (Month) Dec. (Day) 25 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Feb. 23-1863

9. AGE last birthday: 86 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher Niner

14. MOTHER'S MAIDEN NAME: Christina -- unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. T.W. Brailor 409 Walnut St Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| 4343 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 186a | (b) Coronary sclerosis (marked) | ? |
| | (c) Cardiac hypertrophy (marked) | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [*] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [*] CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: daughter home of Grand (CITY OR TOWN) Cresaptown (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 27/49 (Year) (Hour) about 11 P. m.
INJURY OCCURRED While at work [ ] Not while at work [*]
HOW DID INJURY OCCUR? Fell to floor and fractured her right femur.

22. *I certify that I took charge of the remains described above, held an Autopsy [*], Inspection [*] Inquiry [*] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [*], accident [*], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE: H.V. Deming M.D. (Degree or title) ADDRESS: H. V. Deming M.D. Cumberland Md. DATE SIGNED: Dec. 26-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Dec 28.1949
NAME OF CEMETERY OR CREMATORY: St Ambrose Cem
LOCATION (City, town, or county) (State): Cresaptown Md

DATE REC'D BY LOCAL REG.: Dec. 27, 1949
REGISTRAR'S SIGNATURE: W.R. Hartz, M.D.

24. FUNERAL DIRECTOR: William H Wright
ADDRESS: Cumberland Md

RECEIVED
JAN 4 1950
BUREAU V. S.

Within corporate limits

11336

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Allegany Cumberland — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital | STREET ADDRESS (If rural, give location): Route 3, Bowmans Addition |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Robert | Lee | Kave | Dec | 18 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days / Hours / Min. |
|---|---|---|---|---|---|
| Male | White | Widowed | Oct. 14, 1868 | 81 yrs. | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Orchard Worker | Fruit Orchard | Virginia | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert Kave | Elizabeth Berry |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Mrs. Thomas Alderton, Paw Paw, W. Va. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) congestive heart failure | 6 months |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 420.0 93d | (b) arteriosclerotic heart disease | 1 year |
| | (c) cystic pyelitis | 1 month |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 11-17-, 1949, to 12-18-, 1949, that I last saw the deceased alive on 12-17-, 1949, and that death occurred at 4 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| L. Weiss | MD | 57 Greene St. | 12-18-49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/1949 | Woodrow Cemetery | Woodrow, W. Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 19 1949 | Hunter R. Trautz, M.D. | W. D. Parks, | Berkeley Springs, W.Va. |

RECEIVED
DEC 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11337

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS B&O.R.Ry backshop yards

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 310 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Martin (Last) Keech
4. DATE OF DEATH: (Month) Dec (Day) 9 (Year) 1949

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Jan.8-1885 | 64 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shopyard foreman | B&O.R.Ry | Cumberland Md. | U.S.A. |

13. FATHER'S NAME: George E. Keech
14. MOTHER'S MAIDEN NAME: Annie Rooney

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | | 705-09-9879 | Wife) Mary B.B.Keech |

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

420.1
940a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | Cumberland Md. | Dec.9-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 12 1949 | Greenmount Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 11, 1949 | Hunter L. Kantz M.D. | William H. Kight | Cumberland, Md. |

VS. A15A

RECEIVED
DEC 22 1949
BUREAU V. S.

mw

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

11338

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Corrigansville
LENGTH OF STAY (in this place) at once
HOSPITAL OR INSTITUTION OR STREET ADDRESS B&O.R.Ry

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mann's Choice (rural)
STREET ADDRESS (If rural give location) R.F.D.1

3. NAME OF DECEASED (Type or Print) (First) Dale (Middle) Henry (Last) Kelley
4. DATE OF DEATH (Month) Dec. (Day) 18 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Oct.11-1931
9. AGE last birthday 18 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY farm
11. BIRTHPLACE (State or foreign country) Mann's Choice Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME GeorgeKelley
14. MOTHER'S MAIDEN NAME Leila Brant
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 177-24*-9904
17. INFORMANT Zeigler's Funeral Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Intracranial hemorrhage due to a badly | at once |
| 810.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) fractured skull, also had a fractured left | humerous |
| 170a | & left clavicle, right humerous. | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B&O.R.Ry. near (CITY OR TOWN) Corrigansville (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Dec.18/49 12.35 A. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Passenger Train. Auto.stalled on tracks, hit by a

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Dec.18-1949

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF Dec 21 1949 NAME OF CEMETERY OR CREMATORY Dry Ridge Reformed LOCATION (City, town, or county) Bedford Co (State) Pa

DATE REC'D BY LOCAL REG. Dec. 19, 1949 REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D. 24. FUNERAL DIRECTOR Harvey Zeigler Hyndman Pa ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

11339

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rawlings
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Paul (Middle) Horace (Last) Kemp
4. DATE OF DEATH: (Month) Dec. (Day) 9 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Oct.1-1921
9. AGE last birthday: 28 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Substation man
10b. KIND OF BUSINESS OR INDUSTRY: Potomac Edison
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles L. Kemp
14. MOTHER'S MAIDEN NAME: Lola A.Liller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 215-12-2377
17. INFORMANT: Memorial Hospital, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) 2nd.&3rd.burns of body(extensive) came in | 5 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) contact with a 33,000 volt tention line. | |
| | (c) Anuria | |

914.3
193

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office, etc.): Power Plant Potomac Edison Co.
(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Dec.4/49- P. m. 1.45
INJURY OCCURRED While at work [X] Not while at work [ ]
HOW DID INJURY OCCUR? Right hand came in contact with a high tention line.

22. *I certify that I took charge of the remoins described obove, held an Autopsy [X], Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: noturol causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title): H.V.Deming M.D. H.V.Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Dec.9-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Dec. 11, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 11, 1949
REGISTRAR'S SIGNATURE: Winter R Lantz M.D.
24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland, Md.

RECEIVED
DEC 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

11340

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt.Savage
LENGTH OF STAY (In this place): 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Max's Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage
STREET ADDRESS (If rural give location): Max's Hill

3. NAME OF DECEASED (Type or Print): (First) Neoma (Middle) N. (Last) Lambert

4. DATE OF DEATH: (Month) Dec. (Day) 19 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 6-1906

9. AGE last birthday: 43 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Acetate worker

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Wymer W.Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Statten Lambert

14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-8632

17. INFORMANT: John H.Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) also had coronary sclerosis & arteriosclerosis | |
| | (c) | |

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: Dec.20-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 12-23-1949

NAME OF CEMETERY OR CREMATORY: Methodist Cem.

LOCATION (City, town, or county) (State): Mt.Savage, Md.

DATE REC'D BY LOCAL REG.: Dec 22-49

REGISTRAR'S SIGNATURE: Vernon McDermott

24. FUNERAL DIRECTOR: Jacob Hafer

ADDRESS: Frostburg, Md.

RECEIVED
DEC 27 1949
BUREAU V. S.

11341

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Daniel (Middle) (Last) Lancaster

4. DATE OF DEATH: (Month) Dec (Day) 20 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Aug 27, 1909 | 9. AGE last birthday: 40 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile Worker | 10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas Lancaster | 14. MOTHER'S MAIDEN NAME: Mac Farland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War | 16. SOCIAL SECURITY NO. 216-05-5420 | 17. INFORMANT: John Lancaster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Obstruction (Angina) — Interval between onset and death: 1 hr.

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 91a (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/20, 1949, to 12/20, 1949, that I last saw the deceased alive on 12/20, 1949, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Paul Eugene Frye, M.D. — Lonaconing Md 12/22/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Dec 23, 1949 | NAME OF CEMETERY OR CREMATORY Allegany Cemetery | LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 12-22-49 | REGISTRAR'S SIGNATURE Jannette M Beal | 24. FUNERAL DIRECTOR M. Eichhorn | ADDRESS Lonaconing, Md

VS. A15

RECEIVED
DEC 27 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11342

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 2.1/2 hrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 214 Pulaski St.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Ralph (Last) Lashorn

4. DATE OF DEATH: (Month) Dec. (Day) 19 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: July 3-1873

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired trackman

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): Piedmont W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Lashorn

14. MOTHER'S MAIDEN NAME: Helen Jarboe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-05-9340

17. INFORMANT: Mrs. Charles Lashorn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intra-abdominal hemorrhage due to — Interval Between Onset and Death: 2.3/4 hrs

8125 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 1700 (b) a fracture of the pelvis.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: N.Center St (CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec.19/49-10Am.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Crossing street & hit by an auto.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H.V.Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Dec.19-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF: 12/22/1949 NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Dec. 24, 1949 REGISTRAR'S SIGNATURE: Hunter R. County Md.

24. FUNERAL DIRECTOR: Williamm H. Kight ADDRESS: Cumberland, Md.

VS. A15A

RECEIVED
DEC 28 1949
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11343

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Christie Rd. R.F.D. #2 ~~near Cumb.~~

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland,
STREET ADDRESS (If rural, give location) Christie Rd. ~~near Cumb.~~ R.F.D. #2

3. NAME OF DECEASED (Type or Print) (First) ROSE (Middle) R. (Last) LEASURE

4. DATE OF DEATH (Month) Dec. (Day) 20, (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH June 21, 1879

9. AGE last birthday 70 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Emanuel Valentine

14. MOTHER'S MAIDEN NAME Sarah Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS (Son) Wm. R. Leasure 635 Lincoln St., Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Terminal broncho pneumonia | 12 hrs |
| Antecedent cause(s) | (b) Cerebro-vascular accident | 1 yr. |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Hemiplegia secondary to (b) | 1 yr. |

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1949, to December 20, 1949, that I last saw the deceased alive on December 19, 1949, and that death occurred at 6:00 P m., from the causes and on the date stated above.

SIGNATURE George M. Simons (Degree or title) M.D. ADDRESS 128 Union St Cumberland Md DATE SIGNED 12/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Dec. 23, 1949

NAME OF CEMETERY OR CREMATORY Zion Memorial

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Dec. 23, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
DEC 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

11344

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oakland (Rural)
STREET ADDRESS (If rural give location): R.F.D.2

3. NAME OF DECEASED (Type or Print): (First) Clyde (Middle) Alvin (Last) Liller Jr.

4. DATE OF DEATH: (Month) Dec. (Day) 12 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: March 9-1949

9. AGE last birthday: 0 yrs. If under 1 year: Months 9 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Fort Monroe Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clyde Alvin Liller Sr.

14. MOTHER'S MAIDEN NAME: Yesta Zimmerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Parents

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

500 Immediate cause (a) Asphyxia due to regurgation of stomach — Interval between onset and death: at once

106a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) contents.

(c) Acute tracheal bronchitis — about 2 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V.Deming M.D. H. V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Dec.12-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Dec. 14, 1949 — NAME OF CEMETERY OR CREMATORY: Pleasant Valley — LOCATION (City, town, or county) (State): Pleasant Valley, Md.

DATE REC'D BY LOCAL REG.: Dec. 12, 1949 — REGISTRAR'S SIGNATURE: Walter L. Hartz, M. D.

24. FUNERAL DIRECTOR: Emory Bolden — ADDRESS: Oakland md

VS. A15A

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11345

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp. | STREET ADDRESS (If rural, give location) 432 Greene St., |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) ANNA | (Middle) MARY | (Last) LIPPOLD | 4. DATE OF DEATH | (Month) Dec. 21, (Day) (Year) 1949 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH Feb. 22, 1873 | 9. AGE last birthday 76 yrs. | If under 1 year Months. Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Cumberland, | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME John T. Matt | | 14. MOTHER'S MAIDEN NAME Caroline Zapf | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS Catherine Lippold 432 Greene St. Cumb. Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Massive Cerebral Hemorrhage | 4 days |
| 331 Antecedent cause(s) | (b) Arteriosclerosis | 2 yrs |
| 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 12-18, 1949, to 12-21, 1949, that I last saw the deceased alive on 12-21, 1949, and that death occurred at 2:20 P.M. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| James T. Johnson | J.M.D. | Cumberland Md | 12-22-49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Dec. 24, 1949 | NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul | LOCATION (City, town, or county) (State) Cumberland, Md. |
| DATE REC'D BY LOCAL REG. Dec. 24, 1949 | REGISTRAR'S SIGNATURE Walter K. Hantz, M.D. | 24. FUNERAL DIRECTOR Charles L. George Cumb. Md. | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 28 1949
BUREAU U. S.

11346

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Land (Middle) R. (Last) Loar

4. DATE OF DEATH (Month) 12 (Day) 21 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 12-16-49
9. AGE last birthday yrs. If under 1 year Months. Days 6 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Miner's Hospital
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chester Loar
14. MOTHER'S MAIDEN NAME Dorothy Lans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Chester Loar R-2 #1 Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) ~~Myocarditis~~ Bronchial Pneumonia | 4 days |
| 754.4 Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Myocarditis | 6 days |
| 157a | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/16, 1949, to 12/21, 1949, that I last saw the deceased alive on 12/21, 1949, and that death occurred at 1:20 P m., from the causes and on the date stated above.

SIGNATURE H. E. Gatters (Degree or title) M.D. ADDRESS Frostburg Md DATE SIGNED 12/22/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 12-22-1949 NAME OF CEMETERY OR CREMATORY Loar Cemetery LOCATION (City, town, or county) Lan's Mt. Midland (State) Md.

DATE REC'D BY LOCAL REG. 12-22-49 REGISTRAR'S SIGNATURE Mr. Nancy H. Roe
24. FUNERAL DIRECTOR Joseph Hafer ADDRESS Frostburg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 29 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH 11347

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS-A15

**1. PLACE OF DEATH**
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 516 Columbia Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural, give location) 516 Columbia, Ave.

**3. NAME OF DECEASED** (Type or Print): (First) Earl (Middle) E (Last) Long

**4. DATE OF DEATH**: (Month) Dec (Day) 30 (Year) 1949

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH**: Feb. 13, 1884

**9. AGE** last birthday: 65 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Barber

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Cumberland, Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: James H. P. Long

**14. MOTHER'S MAIDEN NAME**: Mary McMahon

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No — (If year, give war or dates of service)

**16. SOCIAL SECURITY No.**:

**17. INFORMANT AND ADDRESS**: Victor Long 516 Columbia, Ave.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Coronary occlusion — Acute

420.1 Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

94a (b) Hypertension and Arteriosclerosis — 6 years

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. —

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify):

**PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.

**INJURY OCCURRED** While at Work ☐ Not While At work ☐

**HOW DID INJURY OCCUR?**

**22.** I hereby certify that I attended the deceased from 12/20/49, to 12/30/49, that I last saw the deceased alive on 12/30/49, and that death occurred at 9:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John N. Rynn M.D. — ADDRESS Cumberland Md — DATE SIGNED 12/31/49

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE 1-2-50 — NAME OF CEMETERY OR CREMATORY St. Peters + Paul — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE RECD BY LOCAL REG. Jan. 1, 1950 — REGISTRAR'S SIGNATURE Lester K. Kantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc, — ADDRESS Cumberland, Md.

RECEIVED
JAN 9 1950
BUREAU V. S.

Within corporate limits

11348

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 703 St. Mary's Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 703 St. Mary's Ave.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Brenton MALSBERRY Malsberry

4. DATE OF DEATH (Month) Dec. (Day) 16 (Year) 1949

5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH April 6-1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer
10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.
11. BIRTHPLACE (State or foreign country) Hyndman Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Malsberry
14. MOTHER'S MAIDEN NAME Barbara Ritchey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-12-1036
17. INFORMANT Mrs. Veda Bruner (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| Immediate cause | (a) | Coronary occlusion | at once |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | Coronary sclerosis | about 3 months |
| 94a | (c) | | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Dec. 16-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec 20-49
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Dec. 19, 1949
REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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Within corporate limits

11349

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie, Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) Janette (Last) Miller
4. DATE OF DEATH: (Month) Dec (Day) 31 (Year) 1949
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: 12/25/1867
9. AGE last birthday: 82 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown.
14. MOTHER'S MAIDEN NAME: Susan Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT: William A. Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Aneurysm Descending Aorta — 4 yrs

451 / 96 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Partial Bowel Obstruction (Descending) 1 month.

19a. DATE OF OPERATION: Dec 29-1949
19b. MAJOR FINDINGS OF OPERATION: Aneurysm Descending aorta Partial Obstruction Descending Colon
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1943, to Dec 31, 1949, that I last saw the deceased alive on Dec 31, 1949, and that death occurred at 8:45 A m., from the causes and on the date stated above.

SIGNATURE John A Lapper (Degree or title) MD ADDRESS Hyndman Pa DATE SIGNED Jan 1-1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Jan 3 1950 | NAME OF CEMETERY OR CREMATORY Hillcrest | LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Jan. 3 1950 | REGISTRAR'S SIGNATURE Winter K. Frantz, M.D. | 24. FUNERAL DIRECTOR Harry A Feigley ADDRESS Hyndman, Penna.

VS. A15

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Within corporate limits

MR. VAN ORMER

# MARYLAND STATE DEPARTMENT OF HEALTH

11350

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

**1. PLACE OF DEATH**
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 20 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MARYLAND — COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: OAKLAND
STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED** (Type or Print): (First) JOHN (Middle) M. (Last) MILLER

**4. DATE OF DEATH**: (Month) December (Day) 6, (Year) 1949

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): WIDOWED

**8. DATE OF BIRTH**: MAY 12, 1881

**9. AGE** last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Laborer

**10b. KIND OF BUSINESS OR INDUSTRY**: County Roads

**11. BIRTHPLACE** (State or foreign country): MARYLAND

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: CHARLES MILLER

**14. MOTHER'S MAIDEN NAME**: MARY ANN JOHNSON

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: MEMORIAL HOSPITAL, CUMBERLAND, MD.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Nephrosclerosis with Uremia. | ? |
| 446 Antecedent cause(s) | | |
| 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized arteriosclerosis. | ? |
| | (c) Hypertensive Vascular Disease. | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from 1 Oct., 19 49, to 6 Dec. 49, 19 ....., that I last saw the deceased alive on 5 Dec. 49, 19 ....., and that death occurred at 9 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Alfred Van Ormer — ADDRESS: Cumberland, Md. — DATE SIGNED: 6 Dec. 49

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Dec. 8, 1949 — NAME OF CEMETERY OR CREMATORY: Mayersville Cemetery — LOCATION (City, town, or county) (State): Mayersville, Maryland

DATE REC'D BY LOCAL REG.: Dec. 7, 1949 — REGISTRAR'S SIGNATURE: Winter K. Dantz, M.D.

**24. FUNERAL DIRECTOR** — ADDRESS: Emory Bolden Oakland Md

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Within corporate limits

MV

M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

11351

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 306 Beall St.

3. NAME OF DECEASED (Type or Print): (First) Regina (Middle) V. (Last) Miltenberger

4. DATE OF DEATH: (Month) Dec. (Day) 7 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July 7-1880

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Short Gap W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Miltenberger

14. MOTHER'S MAIDEN NAME: Mary Brady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. DeSales Mattingly

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subdural hemorrhage due to contusion of the brain

812.5

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hit by a backing taxicab. — 3 days

170 c

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: N.Center St. — (CITY OR TOWN): Cumberland — (COUNTY): Allegany — (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 4/49 7.50 A. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Hit&knocked down by a backing taxi.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. Dec.7-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 12-10-1949
NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 10, 1949
REGISTRAR'S SIGNATURE: Charles K. Mantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

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BUREAU V. A.

DR. FAW

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11352

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
MARYLAND
LENGTH OF STAY (in this place) 19 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE PA. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARTEMAS
STREET ADDRESS (If rural, give location) Route 1, Box 2

3. NAME OF DECEASED (Type or Print) (First) ELMER (Middle) Harley (Last) MOUNTAIN

4. DATE OF DEATH (Month) December (Day) 2 (Year) 49

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH MAY 23, 1880

9. AGE last birthday 69 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY farming

11. BIRTHPLACE (State or foreign country) PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME AARON MOUNTAIN

14. MOTHER'S MAIDEN NAME MARY [illegible] Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Pearl Mountain - Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Hemorrhage intestinal tract, capillary extravasation type 144 Recurrent. | |
| 570.5 Antecedent cause(s) | (b) Intestinal Obstruction - with resection 9 feet small intestine | 6 weeks |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 122.1 | (c) arteris - arteriosclerotic vascular disease | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct 14, 1949

19b. MAJOR FINDINGS OF OPERATION Intestinal Obstruction - Mechanical

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Oct, 1949, to 2 Dec, 1949, that I last saw the deceased alive on 2 Dec, 1949, and that death occurred at 8:01 A.M. from the causes and on the date stated above.

SIGNATURE Wyker W Faw Jr (Degree or title) MD ADDRESS 5 Washington St Cumberland Md. DATE SIGNED Dec 3 '49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec. 5, 1949
NAME OF CEMETERY OR CREMATORY Mt. Zion Christian Cemetery
LOCATION (City, town, or county) (State) near Cheneysville, Pa.

DATE REC'D BY LOCAL REG. Dec. 4, 1949
REGISTRAR'S SIGNATURE Winter K. Kantz M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md.
ADDRESS

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DR. J. M. BROADUP

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11353

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MD. COUNTY: ALLEGANY ~~208 Spring St.~~ |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 6 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location): 208 SPRING STREET |

| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|
| ELIZABETH O'DONNELL | DEC. 3 49 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | MARCH 3 1893 | 56 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | ~~WEST VIRGINIA~~ Pa. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JOSEPH COLLINS | Cora WOODS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Immediate cause** (a) Chronic Myocarditis — Interval between onset and death: Five years.

422.2 **Antecedent cause(s)**

930 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from December, 1944, to December 3, 1949, that I last saw the deceased alive on December 3, 1949, and that death occurred at 6:20 A. m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| [illegible] M.D. | Cumberland 2, Md. | December 3. 1949 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | St. Mary's Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 4, 1949 | Wm. L. Lantz, M.D. | James F. Scarpelli | Cumberland, Md. |

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Evidence for addition in #18 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11354

FILM No. G 124 FEB 23 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 704 Elm St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 704 Elm St

**3. NAME OF DECEASED** (Type or Print): (First) Alice (Middle) Jane (Last) O'Neal

**4. DATE OF DEATH**: (Month) Dec (Day) 30 (Year) 1949

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Widowed

**8. DATE OF BIRTH**: Nov. 15, 1855

**9. AGE** last birthday: 94 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (State or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Archibald Purdew

**14. MOTHER'S MAIDEN NAME**: Priscilla Dickey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No

(If year, give war or dates of service):

**16. SOCIAL SECURITY No.**: None

**17. INFORMANT AND ADDRESS**: Mrs. Thomas Gordon - 704 Elm St.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Failure | 12 hrs. |
| Antecedent cause(s) | (b) Infirmities of Age | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Arteriosclerosis (2/23/50 (akc) | |

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify, that I attended the deceased from 6/15/49, 19..., to 12/30/49, 19..., that I last saw the deceased alive on 12/30/49, 19..., and that death occurred at 5:00 P.M. m., from the causes and on the date stated above.

SIGNATURE: W. H. Mulhearn (Degree or title) MD — ADDRESS: McKelvey Cumb Md — DATE SIGNED: 1/3/50

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Jan. 3, 1950 — NAME OF CEMETERY OR CREMATORY: German Beneficial — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Jan. 3, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.

**24. FUNERAL DIRECTOR** — ADDRESS: John J. Hoffa Cumberland, Md.

RECEIVED
JAN 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

11355

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland | LENGTH OF STAY (in this place): 40yrs |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland Md. | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.#5 Winchester Rd. | STREET ADDRESS (If rural, give location): R.F.D.#5 Winchester Rd. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Michael John Pendergast | | | 4. DATE OF DEATH (Month) (Day) (Year): 12/3/49 19 | | |
| 5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 5/10/1882 | 9. AGE last birthday: 67 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman painter | | 10b. KIND OF BUSINESS OR INDUSTRY: B&ORR | 11. BIRTHPLACE (State or foreign country): Huttons Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME: Thomas J. Pendergast | | | 14. MOTHER'S MAIDEN NAME: Bridget Rowan | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: 705-14-0561 | 17. INFORMANT AND ADDRESS: Patrick J. Pendergast | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage | 24 hrs |
| Antecedent cause(s) | (b) Hypertension Heart Disease | and years |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

443
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Dec 2, 1949 to Dec 3, 1949, that I last saw the deceased alive on Dec 2, 1949 and that death occurred at ..... m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| F. Alan G. Murray | MD | Cumberland Md. | Dec 5 49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 12/6/49 | NAME OF CEMETERY OR CREMATORY: St. Mary's Cem. | LOCATION (City, town, or county) (State): Cumberland, Md. |
| DATE REC'D BY LOCAL REG.: Dec. 5, 1949 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 29 1949
BUREAU V. S.

Within corporate limits DR. SCHINDLER

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11356

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location) 512 HILL STREET |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) EDNA | (Middle) L. | (Last) POWELL | 4. DATE OF DEATH | (Month) DEC. | (Day) 25 | (Year) 1949 |
| 5. SEX FEMALE | 6. COLOR OR RACE COLORED | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH OCT. 31, 1904 | 9. AGE last birthday 45 yrs. | If under 1 year Months. | Days | If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY USA | | | | |
| 13. FATHER'S NAME WILLIAM H. WILLIAMS | 14. MOTHER'S MAIDEN NAME BESSIE MAE FRANTZ | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Decompensation, — 1 week,

442 Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive C.V. Renal Disease — years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Oct. 1, 1949, to Dec. 25, 1949, that I last saw the deceased alive on Dec. 25, 1949, and that death occurred at 6:35 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| B. M. Schindler | MD | 41 Greenwood, Cumberland, Md | 12/26/49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 28 1949 | Rose Hill Cemetery | Cumberland, Maryland. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Dec. 27, 1949 | Winter R. Frantz, M.D. | William H. Kight, Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11357

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 225 Maple St. | STREET ADDRESS (If rural, give location): 225 Maple St. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print): (First) Minnie (Middle) M. (Last) Radcliffe | 4. DATE OF DEATH: (Month) Dec (Day) 31 (Year) 1949 | | | | | | |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: 1-12-1905 | 9. AGE last birthday: 44 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Cumberland, Md | 12. CITIZEN OF WHAT COUNTRY? USA. | | | | |
| 13. FATHER'S NAME: John H Maffley | 14. MOTHER'S MAIDEN NAME: Anna M. Meyers | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT AND ADDRESS: W.F. Radcliffe, Cumberland, Md | | | | |

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cardiac failure | 2 days |
| Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic nephritis | 6 mo. |
| | (c) | |

592
131 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) | (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 12-28, 1949, to 12-31, 1949, that I last saw the deceased alive on 12-31, 1949, and that death occurred at 1:30 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank Dyer, M.D. | | 247 Virginia Ave | 12-31-49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-2-50 | Rose Hill | Cumberland Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 1, 1950 | Lester L. Lantz, M.D. | Louis Stein, Inc. | Cumberland, Maryland. |

RECEIVED
JAN 5 1950
BUREAU V. S.

M

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11358

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (If this place) 88 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 618 Fairview Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 618 Fairview Ave.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Theresa (Last) Reichert

4. DATE OF DEATH (Month) Dec (Day) 14 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept 17, 1861
9. AGE last birthday 88 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY U S A

13. FATHER'S NAME William Mehring
14. MOTHER'S MAIDEN NAME Beradine —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Ev (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS George J Reichert

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

832 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

INTERVAL BETWEEN ONSET AND DEATH: 4 days; several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1949, to Dec 14, 1949, that I last saw the deceased alive on Dec 14, 1949, and that death occurred at 7 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray M.D. ADDRESS Cumberland Md DATE SIGNED Dec 15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec 17, '49
NAME OF CEMETERY OR CREMATORY St Peter & Paul's Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Dec. 16, 1949
REGISTRAR'S SIGNATURE Hunter R Trantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

RECEIVED
DEC 22 1949
BUREAU V. S.

1 Within corporate limits

DR. W. F. WILLIAMS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11359

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, | LENGTH OF STAY (In this place) 8 DAYS |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near CUMBERLAND, Rural |
| | STREET ADDRESS (If rural, give location) ROUTE # 6, PARK HEIGHTS |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| WILLIAM | H. | REYNOLDS | 12- | 29- | 49 19 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | MAY 7, 1884 | 65 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| attendent | State Hospital | MARYLAND | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| LAWSON Reynolds | LOUISE BENDER |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yr., give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| NO | 217 10 9541 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Carcinoma of Larynx. | ? |
| 161 Antecedent cause(s) | | |
| 47a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 12-21-, 1949 to 12-29-, 1949 that I last saw the deceased alive on 12-29-, 1949 and that death occurred at 6:10 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W. F. Williams | | Cumberland | 12/30/49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/50 | Hil Crest Burial Park | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 30, 1949 | Verda L. Hank, M.D. | William H. Kight | Cumberland, Md. |

RECEIVED
JAN 4 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

11360

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.D. #2 Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. D. #2 Cumberland, |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. #2 ~~Cumberland~~ Baltimore Pike, | STREET ADDRESS (If rural, give location) Balto. Pike near Cumb. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| Millard | Fillmore | Rice | Dec. 10, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Apr. 3, 1857 | 92 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Farmer | Near Cumberland, Md. | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Rice | Rebecca Bucy |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Miss Ivalew Rice R.D.#2 Cumb. Md. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Generalized arteriosclerotic Cardio-Vascular-Renal disease | |
| 422.1 Antecedent cause(s) | | |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Gangrene of Toes Left foot. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Sept., 1938, to Dec. 11, 1949, that I last saw the deceased alive on Dec. 10, 1949 and that death occurred at 1:00 A. m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| B. M. Schneidler M.D. | 41 Greene St. Cumberland, Md. | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 12, 1949 | Rose Hill | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 11, 1949 | Winter R. Lantz. M.D. | Charles L. George | Cumberland, Md. |

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11361

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 19 N. Lee St

**3. NAME OF DECEASED (Type or Print)**: (First) Gertrude (Middle) Irene (Last) Shaffer

**4. DATE OF DEATH**: (Month) 12 (Day) 16 (Year) 1949

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: Single

**8. DATE OF BIRTH**: 3/6/20

**9. AGE last birthday**: 29 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**: None

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE (State or foreign country)**: Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Britton O. Shaffer

**14. MOTHER'S MAIDEN NAME**: Bertha DeMoss

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: No — (If year, give war or dates of service):

**16. SOCIAL SECURITY No.**: None

**17. INFORMANT AND ADDRESS**: Father

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremic Poisoning | 4 Two. |
| 591 Antecedent cause(s) | | |
| 1318 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Tubular Nephritis | 5 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**:

**PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)**: (CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY (Month) (Day) (Year) (Hour)**: m.

**INJURY OCCURRED While at Work ☐ Not While At work ☐**

**HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Oct 12, 1949, to Dec. 16, 1949, that I last saw the deceased alive on Dec. 16, 1949, and that death occurred at 7:19 P. M., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title): M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Dec. 17, 1949

**23. BURIAL, CREMATION, REMOVAL (Specify)**: Burial — DATE: 12-19-1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 19, 1949 — REGISTRAR'S SIGNATURE: Hunter R. Trantz, M.D.

**24. FUNERAL DIRECTOR**: Charles L. George — ADDRESS: Cumberland, Md.

RECEIVED
DEC 28 1949
BUREAU V. S.

Within corporate limits L. Bro 8

11362

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany | STREET ADDRESS (If rural, give location) 163 N. Mechanic St., |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) MARY | (Middle) DOMINICA | (Last) SHANNON | 4. DATE OF DEATH | (Month) Dec. (Day) 25, (Year) 1949 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH May 17, 1881 | 9. AGE last birthday 68 yrs. | If under 1 year Months Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Columbus, Ohio | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 13. FATHER'S NAME Thomas D. Cassady | | 14. MOTHER'S MAIDEN NAME Phoebe Perffers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT AND ADDRESS Thomas F. Shannon, 429 N Centre St. Cumberland Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Lymphosarcoma | 2 months |
| 200.1 Antecedent cause(s) | | |
| 55a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION 11-15-49 | 19b. MAJOR FINDINGS OF OPERATION biopsy lymphosarcoma | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Oct. 15, 1949, to Dec. 25, 1949, that I last saw the deceased alive on Dec. 24, 1949, and that death occurred at 9:20 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | MD | 57 Green St. Cumberland | 12-26-49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Dec. 28, 1949 | NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul | LOCATION (City, town, or county) (State) Cumberland, Md. |
| DATE REC'D BY LOCAL REG. Dec. 27, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz M.D. | 24. FUNERAL DIRECTOR Charles L. George | ADDRESS Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 4 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11363

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 36 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 436 Race St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 436 Race St

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Estel (Last) Shelley
4. DATE OF DEATH: (Month) Dec. (Day) 4 (Year) 19 49

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov.12-1913
9. AGE last birthday: 36 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter apprentice
10b. KIND OF BUSINESS OR INDUSTRY: Flood Control
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Theodore C. Shelley
14. MOTHER'S MAIDEN NAME: Bertha Maybelle Riggleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 215-12-2199
17. INFORMANT: Wife) Mrs. C.E.Shelley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — at once

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. Dec.4-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Dec 7 1949 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery | LOCATION (City, town, or county) (State): Near Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Dec. 5, 1949 | REGISTRAR'S SIGNATURE: Wouter R. Frantz, M.D. | 24. FUNERAL DIRECTOR: James F. Scarfelli, Cumberland, Maryland | ADDRESS

VS. A15A

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DEC 13 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11364

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 816 Hill Top Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 816 Hill Top Drive.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Bender (Last) Shoemaker

4. DATE OF DEATH: (Month) Dec (Dey) 2 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 16, 1880

9. AGE last birthday: 69 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Dentist

10b. KIND OF BUSINESS OR INDUSTRY: Dentist

11. BIRTHPLACE (State or foreign country): Buffalo Mills, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James P. Shoemaker

14. MOTHER'S MAIDEN NAME: Amanda Bender

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Shoemaker, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval between onset and death: 48 hrs

190 Antecedent cause(s)

53 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malignant melanoma — 3 yrs

(c)

If. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 29, 1949, to Dec. 2, 1949, that I last saw the deceased alive on Dec. 2, 1949 and that death occurred at 4:45 A m., from the causes and on the date stated above.

SIGNATURE Hunter A. Boyer (Degree or title) M.D. ADDRESS 247 Virginia Ave DATE SIGNED 12-3-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE Dec 4, 1949 | NAME OF CEMETERY OR CREMATORY Dry Ridge Cemetery | LOCATION (City, town, or county) near Buffalo Mills (State) Pa

DATE REC'D BY LOCAL REG. Dec 4, 1949 | REGISTRAR'S SIGNATURE Wesley K. Bantz, M.D. | 24. FUNERAL DIRECTOR John J Hafer ADDRESS Cumberland Md

DEC - 3 1949

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DEC 14 1949
BUREAU V. S.

DR. VAN ORMER

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11365

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: GARRETT |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 4 DAYS | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FRIENDSVILLE |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL Hospital | STREET ADDRESS (If rural, give location): ✓ |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| ALVIN | G. | SINES | DEC. | 18 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | MARCH 5, 1891 | 58 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CARPENTER & PAINTER | CARPENTER | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JOSEPH SINES | THERESA DE WITT |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | MEMORIAL HOSPITAL |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| **Immediate cause** | (a) Coronary occlusion with thrombosis, ant. type. | appox 10 days |
| **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension & Coronary Heart disease | 2 years. |
| 420.1 | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Dec. 13, 19..., to Dec. 18, 1949, that I last saw the deceased alive on Dec. 18, 1949, and that death occurred at 5:25 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W. A. Van Ormer | M.D. | Cumberland, Md | Dec. 20, 49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 21, 1949 | Savage Addition Cemetery | Friendsville, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 21, 1949 | Hunter R. Frantz, M.D. | H. H. Savage | Friendsville Md |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 28 1949
BUREAU V. S.

DR.W.F.WILLIAMS

Within corporate limits

11366

65

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 2 DAYS | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location) 208 GLENN STREET |

3. NAME OF DECEASED (Type or Print): (First) ROSE (Middle) Catherine (Last) SMITH

4. DATE OF DEATH: (Month) DEC. (Day) 31 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: APRIL 18, 1882

9. AGE last birthday: 67 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM KIRBY

14. MOTHER'S MAIDEN NAME: MARGARET PORTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocardial Degeneration

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93d (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-20, 1949, to 12-31, 1949, that I last saw the deceased alive on 12/31, 1949, and that death occurred at 5:40 p.m., from the causes and on the date stated above.

SIGNATURE: W.F. Williams (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 1-2-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan. 2, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county): Cumberland, (State) Md.

DATE REC'D BY LOCAL REG.: Jan. 1, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, ADDRESS: Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

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JAN 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

11367

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 83 Frost Avenue

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) JOSEPH (Last) STAPLETON

4. DATE OF DEATH: (Month) Dec (Day) 31 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 6-2-1927

9. AGE last birthday: 22 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student

10b. KIND OF BUSINESS OR INDUSTRY: school

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John P. Stapleton

14. MOTHER'S MAIDEN NAME: Mary Winner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): WW 2

16. SOCIAL SECURITY No.: 216-22-6475

17. INFORMANT AND ADDRESS: John P. Stapleton, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) acute Encephalitis type undetermined | 2 Days |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Virus Infection | 1 mo |
| | (c) | |

082
10 4 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1949, to Dec 31, 1949, that I last saw the deceased alive on Dec 31, 1949, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W O'Mc Lane | M D | Frostburg Md | 1-2-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-50 | St. Michaels Cemetery | Frostburg, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 1-3-50 | Mrs Nancy K. Roe | J. R. Durst, Frostburg, Md. |

RECEIVED
JAN 6 1950
BUREAU V. S.

DR. TOLSON

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11368

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 50 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) WASHINGTON LEE APTS.

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) J. (Last) STUMP.
4. DATE OF DEATH (Month) DEC. (Day) 16 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH SEPT. 24 1873
9. AGE last birthday 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY Insurance Broker
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN STUMP
14. MOTHER'S MAIDEN NAME SUSAN KERNS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Dr John J Stump Jr. New York City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 Immediate cause (a) Arteriosclerosis

Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1949, to 12-16, 1949, that I last saw the deceased alive on 12-16-, 1949, and that death occurred at 12:15 P m., from the causes and on the date stated above.

SIGNATURE Howard L. Tolson, M.D. (Degree or title) ADDRESS Cumberland, Md DATE SIGNED 12-16-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec 19 49
NAME OF CEMETERY OR CREMATORY St Peter & Paul's Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Dec 17, 1949
REGISTRAR'S SIGNATURE Hunter R Trantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11369

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3.1/2days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 118 Green St.

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) C. (Last) Vernay

4. DATE OF DEATH: (Month) Dec. (Day) 13 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Jan.4-1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Winchester Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Clayton

14. MOTHER'S MAIDEN NAME: Mary Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Stein's Funeral Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Died suddenly on O.R.table. — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (?) (a) D.M.Examiner ordered Autopsy and sent body

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) to morgue at Memorial Hospital.

902.5 186a

(c) Husband refused to have autopsy performed & threats.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: No autopsy by Dr. Skiteralic due to husband refusing same. — by D.M.Exam.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒ requested

21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Green St. — (CITY OR TOWN): Cumberland — (COUNTY): Allegany — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec.9/49-8-P. m.

INJURY OCCURRED While at work ☐ Not while at work *

HOW DID INJURY OCCUR? Stepped from curb turned ankle, causing fracture of femur.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, (undetermined ☒. exact cause, immediate)*

I tried / ordered

SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. — (Degree or title) — ADDRESS: Cumberland Md. — DATE SIGNED: Dec.13-1949

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: Dec 15 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill — LOCATION (City, town, or county) (State): Cumberland

DATE REC'D BY LOCAL REG.: Dec. 15, 1949 — REGISTRAR'S SIGNATURE: Hunter R Dauty, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Louis Stein Inc

RECEIVED
DEC 22 1949
BUREAU V. S.

DR. ENFIELD

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 45 YRS. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD. | STREET ADDRESS (If rural, give location) 118 GREEN STREET |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| LAURA | C. | VERNAY | DEC. | 13 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | JAN. 4 1874 | 75 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | VIRGINIA | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| DAVID L. CLAYTON | MARY ARNOLD |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| No | — | | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure few min

Antecedent cause(s) (b) Fracture of neck of femur

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Patient was being put to sleep with gas ether anesthesia

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| accident | street | Cumberland | | Md |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☑ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| Dec | 9 | 1949 | 8 P m. | | Fall from street curb |

22. I hereby certify that I attended the deceased from Dec 9, 1949, to Dec 13 1949, that I last saw the deceased alive on Dec 13, 1949, and that death occurred at 9:58 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| S E Enfield | | Cumberland | 12/13/49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Dec 1549 | Rose Hill Cem | Cumberland | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 15, 1949 | Vinta R Frantz, M.D. | Louis Stein Inc | Cumberland Md |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

11370

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 330 1/2 N. Mechanic St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Edward | Clarence | Walker | Dec. | 17 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | single | June 23-1877 | 72 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber's helper | Plumbing | Allegany Co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Walker | Barbara Weigand |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | 212-24-1539 | Roy Walker (brother) |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Myocarditis | ? |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Coronary sclerosis | ? |
| | (c) arteriosclerosis (alcoholic) | ? |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H.V. Deming M.D. | Cumberland Md. | Dec. 17-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-19-49 | Hillcrest Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 19, 1949 | Hunter R. Trantz, M.D. | Louis Stein, Inc. | |

VS. A16A

RECEIVED
DEC 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11371

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 119 Pennsylvania Ave.

**3. NAME OF DECEASED** (Type or Print): (First) Harry (Middle) Venners (Last) Whalley

**4. DATE OF DEATH**: (Month) 12 (Day) 7 (Year) 1949

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: Widowed

**8. DATE OF BIRTH**: Dec. 29, 1872

**9. AGE last birthday**: 76 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Tin Mill Roller

**10b. KIND OF BUSINESS OR INDUSTRY**: Retired

**11. BIRTHPLACE** (State or foreign country): Allegany Co. Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Carlos Whalley

**14. MOTHER'S MAIDEN NAME**: Sarah Butler

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service): No.

**16. SOCIAL SECURITY No.**: None

**17. INFORMANT AND ADDRESS**: son - John Whalley Cumberland, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 2 1/2 hrs. |
| 332 Antecedent cause(s) | | |
| 83 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cerebral Arteriosclerosis | 1 year |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)** | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 16, 1949, to Dec. 7, 1949, that I last saw the deceased alive on Dec. 4, 1949, and that death occurred at 2:05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M.D. | 110 S. Centre St. | Dec. 8, 1949

23. BURIAL, CREMATION OR REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial | Dec. 9, 1949 | Hillcrest Cemetery | New Cumberland, Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Dec. 8, 1949 | Walter L. Frantz, M.D. | James F. Scarpelli | Cumberland, Md.

RECEIVED
DEC 13 1949
BUREAU V. S.

Within corporate limits

DR. W. F. WILLIAMS
Resident Owner

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11372

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 49 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 510 PEARRE AVENUE

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | ERNEST | Dillan | WILSON | | 12 | 5 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | DIVORCED | JULY 9 1885 | 64 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| RETIRED | RETIRED | MARYLAND | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HARVEY WILSON | MARIE J. FRANTZ |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | MEMORIAL HOSPITAL |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Renal Failure with Uremia | 3 months |
| Antecedent cause(s) | (b) Coronary Heart Disease | 6 months |
| Underlying cause last | (c) Hypertensive vascular Disease | ? |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Nephrosclerosis | ? |

420.1
131a

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from 5 Nov., 1949, to 5 Dec., 1949, that I last saw the deceased alive on 5 Dec., 1949, and that death occurred at 3 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W. Alfred Van Ness | | Cumberland, Md. | 5 Dec. 49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 7, 1949 | Rose Hill Cemetery | Cumberland, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec. 7, 1949 | Winter R. Frantz, M.D. | John J. Hafer | Cumberland, Md. |

RECEIVED
DEC 13 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11373

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 60yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS I06 Mullan St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) I06 Massachusett Ave.

3. NAME OF DECEASED (Type or Print): (First) Mary [redacted] (Middle) M. (Last) Wilson

4. DATE OF DEATH: (Month) (Day) (Year) I2/I2/49 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 22I88I

9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Greenridge, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Smith

14. MOTHER'S MAIDEN NAME: Eliza Barns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Violette Catanese Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Hypertensive C.V. Disease — Interval Between Onset and Death: years.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis — years.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 49, to Dec 12, 19 49, that I last saw the deceased alive on Dec. 11, 19 49, and that death occurred at 2:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

B. M. Schmidler M.D. | 41 Greene St, Cumberland, Md. | Dec 12, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: I2/I4/49 | NAME OF CEMETERY OR CREMATORY: St. Mary's Cem | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Dec. 13, 1949 | REGISTRAR'S SIGNATURE: Ernest R. Kantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md.

RECEIVED
DEC 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11374

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 51 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): York Hotel

3. NAME OF DECEASED (Type or Print): (First) Lulu (Middle) Bertella (Last) Winterberg

4. DATE OF DEATH: (Month) Dec. (Day) 23 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July4-1867

9. AGE last birthday: 82 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Cresaptown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John S. Winters

14. MOTHER'S MAIDEN NAME: Harriett Siegler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostatic (passive)congestion of the lungs — about 1 week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 900.0 / 186a

(b) Thrombous with dicubital ulcer of right lower leg.

(c) arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: York Hotel
(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): about 5.30 Nov.1/49 P. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR?: Accidently fell down stairs.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. — ADDRESS: H.V. Deming M.D. Cumberland Md. — DATE SIGNED: Dec.24-1949

23. BURIAL, CREMATION REMOVAL, (Specify): Burial
DATE THEREOF: Dec. 26, 1949
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Dec. 26, 1949
REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.
24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md.
ADDRESS

VS. A15A

RECEIVED
JAN 4 1950
BUREAU V. S.

DR. GRACIE

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11375

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 24 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: WEST VIRGINIA — COUNTY: Hardy
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MOOREFIELD
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) CORA (Middle) M. (Last) WOERNER

**4. DATE OF DEATH**: (Month) DEC. (Day) 18 (Year) 1949

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED

**8. DATE OF BIRTH**: MARCH 15 1894

**9. AGE last birthday**: 55 yrs. — If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): W.VA.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: WILLIAM M. KESSEN

**14. MOTHER'S MAIDEN NAME**: HANNA BURGDOLL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: MEMORIAL HOSPITAL

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

584 **Immediate cause** (a) Anemia, Cardiovascular Renal

126 **Antecedent cause(s)** Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gall Bladder Fistula

(c)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**: Nov 19-49

**19b. MAJOR FINDINGS OF OPERATION**: Stones in Gall Bladder + Common D

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 14, 1949, to Dec 18, 1949, that I last saw the deceased alive on Dec 18, 1949, and that death occurred at 1-50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W.A. Gracie MD — ADDRESS: Cumberland Md — DATE SIGNED:

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Dec. 20, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery — LOCATION (City, town, or county) (State): Moorefield, W. Va.

DATE REC'D BY LOCAL REG.: Dec. 18, 1949 — REGISTRAR'S SIGNATURE: Virntes R. Kantz, M.D.

**24. FUNERAL DIRECTOR** — ADDRESS: O. L. Fluharty & Son, Moorefield, West Virginia

RECEIVED
DEC 28 1949
BUREAU U. S.

Outside of City Limits

11376

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Rural~~ near Corrigansville
LENGTH OF STAY (In this place) at once
HOSPITAL OR INSTITUTION OR STREET ADDRESS B&O.R.Ry

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Schellsburg (rural)
STREET ADDRESS (If rural give location) R.F.D.1

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Joseph | Phillip | Wolfhope | Dec | 18 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | May 25-1920 | 29 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Garage mechanic | Repair Auto. | New Baltimore Pa. or Johnstown Pa. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Clement Wolfhope | Theresea Restley |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| Yes W.W. 2 | 172-18-1646 | Zeigler's Funeral Home |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Intracranial hemorrhage due to a crushed | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) skull, also had a compound Comminuted fracture right | |
| 810.5 1700 | (c) lower leg, fractured nose & bones of face. | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lacerations & abrasions of body.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ✱ OR CONTRIBUTING ✱ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | B&O.R.Ry near | Corrigansville | Allegany | Md. |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| Dec.18/49 12.35 A. m. | | Passenger Train. Auto. stalled on tracks, hit by |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | | Cumberland Md. | Dec.18-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | Dec 21 1949 | New Baltimore Catholic | New Baltimore | Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Dec 19, 1949 | Hunter R Dantz, M.D. | Ziegler Funeral Home, | Hyndman, Pa. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 28 1949
BUREAU V. S.

11377

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole - Rural — LENGTH OF STAY (in this place) — | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole - Rural |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mi no of McCoole | STREET ADDRESS (If rural, give location) 1 mi no of McCoole |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Baby | (Middle) Boy | (Last) Wolford | 4. DATE OF DEATH | (Month) Dec | (Day) 17 | (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH Dec 17, 1949 | 9. AGE last birthday — yrs. | If under 1 year Months — | Days — | If under 24 hrs. Hours — Min. 5 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? — | | | | |
| 13. FATHER'S NAME Thomas J. Wolford | 14. MOTHER'S MAIDEN NAME Eunice Bare | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT AND ADDRESS Thomas Wolford, McCoole, Md | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity (6 mo)

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Dec 17, 1949, to Dec 17, 1949 that I last saw the deceased alive on Dec 17, 1949, and that death occurred at 12 30 a m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| James H. Webster Jr | MD | Piedmont W. Va. | 12/17/49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Dec 17, 1949 | NAME OF CEMETERY OR CREMATORY Bloomington, Cem | LOCATION (City, town, or county) (State) Bloomington, Md |
| DATE REC'D BY LOCAL REG. Dec. 17/49 | REGISTRAR'S SIGNATURE [signature] MD | 24. FUNERAL DIRECTOR E. S. Beal, Western Port, Md | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 20 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11378

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 705 Shriver Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 705 Shriver Ave.,

3. NAME OF DECEASED (Type or Print): (First) Baird (Middle) a (Last) Wolford

4. DATE OF DEATH: (Month) Dec. (Day) 29, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr. 10, 1884

9. AGE last birthday: 65 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired mail Supt.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post office

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. a.

13. FATHER'S NAME: John W. Wolford

14. MOTHER'S MAIDEN NAME: Elizabeth Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Mrs. Hazel Wolford 705 Shriver Ave.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Occlusion

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) None

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At wrk ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1936, to —, 1949, that I last saw the deceased alive on 12/29, 1949 and that death occurred at 11:00 P. m., from the causes and on the date stated above.

SIGNATURE John K. Bozman (Degree or title) M.D. ADDRESS Cumberland Md. DATE SIGNED 12/30/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Jan. 1, 1950 NAME OF CEMETERY OR CREMATORY Rose Hill Cem. LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Dec. 30, 1949 REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

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